The British Psychological Society

SMMGP CLINICAL UPDATE – February 2010

British Psychological Society Faculty of Addiction are guest contributors to this update and have provided and commented on the first two papers.

The 10 most important things about addiction.

Sellman D. Addiction 2009. Jan 2010 doi:10.1111/j.1360-0443.2009.02673x

The author sets out 10 items that he regards as the most important:

(1) Addiction is fundamentally about compulsive behaviour; (2) compulsive drug seeking is initiated outside of consciousness; (3) addiction is about 50% heritable and complexity abounds; (4) most people with addictions who present for help have other psychiatric problems; (5) addiction is a chronic relapsing disorder in the majority of people; (6) different psychotherapies appear to produce similar treatment outcomes; (7) 'come back when you're motivated' is not an acceptable therapeutic response; (8) the more individualised and broad-based the treatment a person with addiction receives, the better the outcome; (9) epiphanies are hard to manufacture; and (10) change takes time.

The title may be whimsical but the paper is a serious digest of the sum total of addiction knowledge. In his summary, Professor Sellman acknowledges the divisions and rivalries amongst addiction professionals and calls for an effort for all those in the addiction field to rise above the 'reptilian' aspects of human nature to work for the benefit of *tangata whaiora* (clients).

British Psychological Society comment:
It is difficult not to be drawn to a paper with a title like this. The author highlights the issue of co-morbid mental health and the need for well-trained staff, skilled in motivational interviewing. The recent NICE guidelines for psychosocial interventions for drug misuse reached similar conclusions and importantly state the need for drug misusers to have access to CBT to treat their mental health problems. A toolkit and framework to help services implement these evidence-based approaches is available on the NTA website in the Routes to Recovery section.

The author sets a challenge to the reader; asking you to devise and compare your own list. Yet what the paper lacks is any reference to the psychological theory developments that can offer some explanation for the author's observations.

To take three of these: *Addiction is fundamentally about compulsive behaviour:* Jim Orford (2001) in his book Excessive Appetites, presents a developmental and explanatory psychological model for both drug and non-drug addictions (gambling, eating, sex etc). *Drug seeking is initiated outside consciousness:* Robert West's (2006) PRIME theory describes a hierarchical representation of the motivational system which drives addictive behaviour and highlights how conscious efforts to desist in the behaviour are put under enormous stress from more primitive drives. *The more individualised the treatment the better the outcome:* Like West, Witkiewitz & Marlatt, (2004), in their dynamic model of relapse draw on catastrophe/chaos theory ideas to explain the shifting dynamic nature of addiction and the relapse process. Their conclusion is that treatment needs to address issues across multiple domains tailored to the specific needs of the client.

Without theoretical models with which to formulate and test hypotheses and implement novel treatments, it is unlikely the author's wish for a rapprochement between researchers and clinicians so as to advance the field will be realised.

Moving away from problematic substance use: The importance of 'identity shift'. *Maslin J, Simons I. Clinical Psychology Forum 201. Sep 2009. Available at tinyurl.com/CPFSep09.*

The Clinical Psychology Forum is published by the British Psychological Society and is 'designed to serve as a discussion forum for any issues of relevance to clinical psychologists, with articles, reports of events, correspondence, book reviews and announcements.'

This article considers some of the issues around 'identity shift' and how clients who can sustain positive changes can go on the achieve 'recovery'. The Lambeth Aftercare Team (ACT) speculated that this concept of 'identity shift' is important in understanding 'some of the psychological underpinnings' of what is helpful for their clients. The ACT ran a series with two parallel groups (discussion and art groups) around the theme of identity to explore the issue.

The discussion group had five clients attending three fortnightly groups discussing the idea of identity change in recovery. At the time of these groups the clients were abstinent from their problem drug and had been in treatment for at least 6 months. The art group had a total of 20 clients attending 11 sessions with the aim of creating a giant jigsaw, made up of individual pieces, produced by the service users.

The paper reported that all the participants in the discussion group found the concept of 'identity shift' meaningful. They considered it to be a gradual process which took time. They also felt the ACT could facilitate this and there was some discussion of practical measures, like mentoring, that could be used. The art group noted that those who had been in recovery longer had a more positive image of themselves. Overall, the explicit discussion of the concept of 'identity shift' had positive benefits for clients on their journey to recovery.

British Psychological Society comment:
One could argue that the notion of a stable as opposed to shifting identity is something of a privilege reserved only for a few insightful souls born with the certainty of their own place in the world. This is, of course, a rarity and in all probability a falsehood; for most of us the struggle to conceptualise ourselves in a coherent fashion is necessary, difficult and meaningful. In existential terms, humans have to confront the fact that their existence precedes their essence and that there is no pre-given place for any of us. Many corruptions can occur in the process of creating self identity and problematic substance use has to rank pretty highly among them. Addiction is, if nothing else, an escape from the temporal self to something far more fanciful and dangerous.

Maslin and Simons are to be congratulated on opening up the question of identity to those in recovery and it is particularly gratifying to see psychologists relinquishing the questionnaire in favour of art and grounded theory. Interestingly, in our experience of running a group for clients undergoing an inpatient detox, we found that while discussions about identity were seen as premature, talking about both lost and desired roles was warmly received.

Whether the sum total of all one's roles constitutes identity is, of course, open to question, but explorations of role and identity arguably constitute the essence of recovery rather more than simple sobriety. We do not become what we are, but are what we become.

Our thanks to Dr Luke Mitcheson and Dr Robert G Hill of the British Psychological Society for their comments. Have you visited the Psychosocial Interventions Resource Library on the NTA website at www.nta.nhs.uk/PIRL? For resources to facilitate discussions about roles and life meaning, look in "New developments in preventing relapse for drug and alcohol dependent adults" (tinyurl.com/krgf5w).

See also the British Psychological Society Faculty of Addiction home page at:

http://www.bps.org.uk/dcp-addiction/dcp-addiction_home.cfm

The Drug Treatment Outcomes Research Study (DTORS): Final outcomes report. 3rd edition. *Jones A, Donmall M, Millar T, et al. Home Office 2009. Available at tinyurl.com/DTORS3*

DTORS is a national multi-site longitudinal study exploring the outcomes of drug treatment in England. There were three main strands to the study: a quantitative study of outcomes, a qualitative study of treatment-related issues,

and a cost-benefit analysis. This report focuses on the first element: the final outcomes.

DTORS recruited their sample from 342 treatment facilities in 94 of the 149 Drug Action Team (DAT) areas in England. During the sampling window (4-7 weeks) any adult presenting with a new episode was eligible for inclusion. A total of 1796 adults were recruited for baseline interview between Feb 2006 and March 2007.

The areas considered in the initial interviews included measures of social functioning, drug use, health-risk behaviour, offending and mental and physical health. All measures were self-reported but the drug use at follow up was validated using saliva screening.

They followed up 1131 (63%) of this baseline sample and managed to interview them again. Most of these were the initial follow-up between 3-5 months when they interviewed around half (n=886). The second follow-up was between 11-13 months and of the 886 there were still 57% (n=504) interviewed.

By the time the second time follow up had been completed 96% had received some form of structured treatment: 65% got substitute prescribing; 58% specialist prescribing; 22% GP prescribing; 50% structured counselling; 26% structured day care; 21% residential rehabilitation; and 11% in-patient detoxification. In those who received substitute prescribing 74% got methadone and the rest buprenorphine.

There were significant reductions in drug use of all types by the time of the initial follow-up interviews. The proportion of those injecting (whether opiates, amphetamines or cocaine) in the past 4 weeks dropped to half. The rate of decline was rapid in the first 3 months and continued at the same rate for up to 6 months. In the heroin users just under half were abstinent by the second follow-up.

Offending behaviour dropped and whereas at the start 40% had committed some kind of acquisitive crime this dropped to 21% at the initial follow up and 16% at the second follow-up. Interestingly, there was little change in physical health measures either before or after the study. The proportion that had overdosed dropped from 9% to 4%. Employment rose from 9% to 16% at second follow up and those in stable housing rose from 60% to 77%.

Notably, those in the criminal justice sector did just as well as any others with similar rates of retention and other positive outcomes.

SMMGP comment:
They don't come much more important than this when it comes to policy in England and the authors' key comment is that 'the overriding finding is that treatment reduces the harmful behaviours associated with problem drug use'. But perhaps we need to pick the bones out of that initial statement.

The study explores the full spectrum of treatment options – from GP prescribing to residential rehabilitation (NTORS was limited to methadone prescribing and inpatient/residential services).

In a study of this nature taking new clients presenting to treatment, it would not be possible to have a true control group but comparing the different interventions again show (as NTORS), that all work but little about how to get the right treatment for the right person and how much of this depends on availability. Also were all eligible new clients included and how significant are the one-third who refused to participate?

It seems curious and disappointing that treatment has had so little effect on physical health. Self-reported scores were 'similar to UK norms before and after treatment'. However, there seems likely to be long-term health benefits from the demonstrated reductions in injecting and also sharing of needles but also many presenting to treatment may have long-term illnesses such as hepatitis C. Clinical experience may make many wonder about the tool or whether this also highlights sample bias. Additionally, it also highlights the weakness of these studies with relatively short follow ups.

Problems experienced by community pharmacists delivering opioid substitution treatment in New South Wales.

Winstock AR, Lea T, Sheridan J. Addiction Feb 2010. doi:10.1111/j.1360-0443.2009.02774.x

This paper was a postal survey of all the pharmacists providing opioid substitution therapy (OST) in New South Wales and Victoria, Australia. The specific areas that the questionnaire addressed were; pharmacy characteristics, recent problems experienced by clients including refusal to dose, termination of

treatment, and responses of pharmacists to problems experienced with clients, including the types of those problems experienced with OST prescribers.

There is an important difference between the two populations in NSW and Victoria. The clients in Victoria tended to be inducted directly into treatment at a community pharmacy without a period of specialist support and stabilisation. NSW services provide specialist clinics and then after at least a 3 month period of daily supervision transfer people to the pharmacy.

The results showed that 41% of pharmacists had refused to give a client their dose for various reasons in the past month. Around 1 in 7 had terminated a client's treatment in the past month for inappropriate behaviour and missed doses. Termination of care was statistically associated with; having more clients, the provision of buprenorphine treatment, having a separate dosing area, and being a female pharmacist.

The most common problem for pharmacists (around 1 in 5) was contacting prescribing doctors and prescribing takeaway doses to clients who were considered unstable.

SMMGP comment:
A limitation of this paper for UK practice is the variation in the model of care. Some of our practice will follow the NSW model but some aspects of primary care treatment may be more accurately reflected in the Victoria community pharmacist model.

That said, the study does highlight the importance of a solid understanding of the issues at all points where clients engage with services. Although the provision of a separate dosing area was associated with an increased risk of termination of care this is possibly due to the improved interaction between pharmacist and client. Although termination of care is clearly undesirable this may have to be weighed against safety issues and better opportunities to deliver other interventions.

Given the most common problem for pharmacists was contacting prescribers there is a clear message from this paper that we need to work to develop links and work in partnership with pharmacists to provide a complete service.

This month, the Birmingham DAAT appointed Kevin Ratcliffe as a Consultant Pharmacist in Substance Misuse and this is well-deserved recognition of the critical role of pharmacists.

Does opioid substitution treatment in prisons reduce injecting-related HIV risk behaviours?

A systematic review. Larney S. Addiction Feb 2010. doi: 10.1111/j.1360-0443.2009.02826.x

This paper presented a systematic review of the evidence on opioid substitution therapy (OST) in prisons and its relationship with reductions in injecting-related HIV risk behaviours.

The author used a Cochrane Collaboration recommended methodology to identify papers and five papers met the inclusion criteria. Only one of these was a randomised trial but they all had a two-group design which compared treated and untreated prisoners.

The outcomes considered were illicit opioid use, injecting drug use, sharing of needles and syringes and HIV incidence. When compared to prisoners in the control groups the risk of injecting drug use was reduced by 55-75% and the risk of needle sharing by 47-73%.

There was no study that reported a direct effect of prison OST on HIV incidence.

SMMGP comment:
The paper highlights the clear international disparity between the implementation of opioid substitution therapy in prisons and the glaring need in some of the worse HIV affected countries. And there is scarcely room for complacency in the UK where the provision of opioid substitution in prisons is varied, often short-term and sub-therapeutic dosing.

The evidence base in this area isn't strong. The studies that have been done show some significant reductions in risks but have been criticised for being methodologically weak.

However, the conclusion that OST can reduce intra-prison HIV transmission is almost certainly safe.

A survey of general practitioners' knowledge, attitudes and practices regarding the prevention and management of alcohol-related problems: an update of a World Health Organisation survey 10 years on. *Lock C, Wilson G, Kaner E et al. Available at tinyurl.com/GPalcoholstudy*

This was a postal questionnaire survey of 419 GP principals in the Midlands and the aim was to assess the current knowledge, attitudes and practices of GPs with regard to brief alcohol interventions. The study had been carried out in 1999 and this was a chance to see how things had changed.

They achieved a 74% response rate. Just over half (52%) had received less than 4 hours training on alcohol issues and 12% had received none. GPs felt that working with problem drinkers was a legitimate part of their role but were less motivated and derived little satisfaction from the work. However, they did feel more motivated than in 1999. The main barrier identified was time and that GPs were not trained in counselling for reducing alcohol consumption. GPs in 2009 ordered more blood tests, treated more patients for alcohol problems and asked about alcohol more often than in 1999.

SMMGP comment: The report recommends that the provision of support to facilitate GPs in asking patients about alcohol is increased and the lack of encouragement for this in the GMS contract was noted. But GP interventions still seem to focus around unstructured interventions and blood tests rather than proven brief interventions. The introduction of the DES for screening of new patients was a real missed opportunity to introduce a proper NES or addition to QOF.

Alarmingly, the levels of postgraduate training are actually lower than 10 years ago. This report pre-dates the introduction of the RCGP Part 1 in Alcohol but it neatly summarises the clear need for this course to be rolled out and made accessible for all GPs.

Anticonvulsant drugs in cocaine dependence: A systematic review and meta-analysis. *Alvarez Y, Farré M, Fonseca F, Torrens M. Journal of Substance Abuse Treatment 2010. (38) 66-73. doi: 10.1016/j.jsat.2009.07.001*

This paper also used the methodology developed by the Cochrane Collaboration to evaluate the evidence for the efficacy of anticonvulsants in patients with cocaine dependence.

They identified 15 randomised double-blind placebo-controlled trials which involved a total of 1236 patients. Their main two outcome measures were: retention in the anticonvulsant treatment and the subsequent cocaine use (measured using urinalysis). A total of seven anticonvulsants were considered as part of these trials; carbamazepine, phenytoin, valproic acid, tiagabine, gabapentin, lamotrigine and topiramate. All were given for at least 8 weeks. Psychosocial therapy was also given in all studies except one.

The results showed that on average 50% of the participants were lost at follow up. The treatments didn't show an improvement in retention versus placebo and neither was there a reduction in the use of cocaine.

SMMGP comment:
The usual caveats apply when considering a meta-analysis. The heterogeneity of the studies was noted by the authors and this is often the grievance of those who feel nervous about meta-analysis. All the studies were in the USA but they were conducted over a 13 year period from 1994 to 2007. The authors specifically highlighted the problem with differences between dosage and duration of treatments.

The impact on the average clinician's care may depend on your feelings on meta-analysis. The 'splitters' may look at one or two studies in isolation and feel there is some role but bearing in mind they are all set in the USA the evidence for their use looks very thin indeed.

If you are a 'lumper' then you will accept that this study provides pretty solid foundation for the assertion that there is no place for anticonvulsants to retain people in treatment or reduce cocaine use. In the meantime, we can all try to hone our psycho-social intervention skills.

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